SPSP Mental Health

Learning System Webinar: Improving Observation Practice – Policy to Practice

Thank you for joining: this event will begin at 13.00
In the meantime, please introduce yourself in the chat.

@SPSP_MH
#SPSPMH

Welcome and introduction

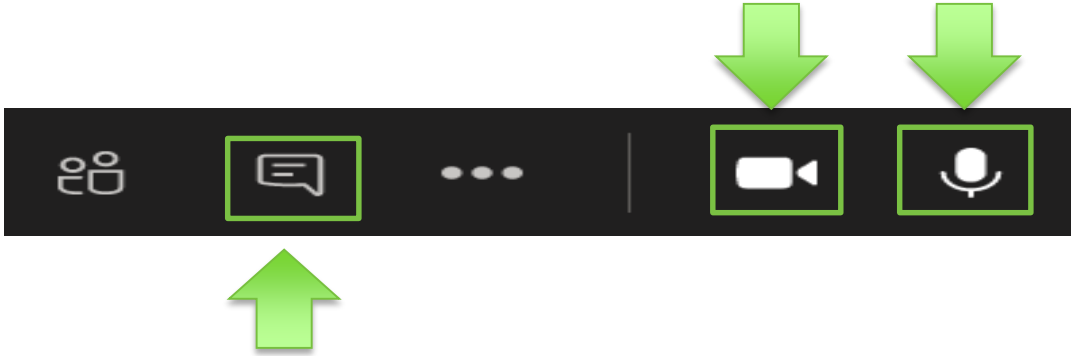
Dr Jane Cheeseman

National Clinical Lead

Healthcare Improvement Scotland

Housekeeping

During the meeting please have your microphone on mute and video turned off. This will avoid distraction and minimise the likelihood of slowing down the technology.



There will be opportunities for Q&A in the planned session. Please pop all questions in the chat box

Some of this session will be recorded.

If you require any technical support please pop in the chat box or contact his.pspcontact@nhs.scot.

Aims of the session

- Overview of SPSP
- Overview of SPSP MH
- A practical example of how the ‘From Observation to Intervention’ guidance is being implemented

Introduction

Scottish Patient Safety Programme: Update

Joanne Matthews
Head of Improvement Support and Safety
Healthcare Improvement Scotland

The Programme

SPSP aims to improve the safety and reliability of care and reduce harm

Core Themes

- **Essentials of Safe Care**
- **SPSP Programme improvement focus Maternity ,Neonatal, Paediatric ,Acute Care, Primary Care, Medicines and Mental Health**
- **SPSP Learning System**

The Essentials of Safe Care

Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME

Aim

To enable the delivery of Safe Care for every person within every system every time

Primary Drivers

- Person centred systems and behaviours are embedded and support safety for everyone
- Safe communications within and between teams
- Leadership to promote a culture of safety at all levels
- Safe consistent clinical and care processes across health and social care settings

Secondary Drivers

- Structures & processes that enable safe, person centred care
- Inclusion and involvement
- Workforce capacity and capability
- Skills : appropriate language, format and content
- Practice : use of standardised tools for communication
- Critical Situations : management of communication in different situations
- Psychological safety
- Staff wellbeing
- System for learning
- Reliable implementation of Standard Infection Prevention and Control Precautions (SICPS)
- Safe Staffing

SPSP Mental Health

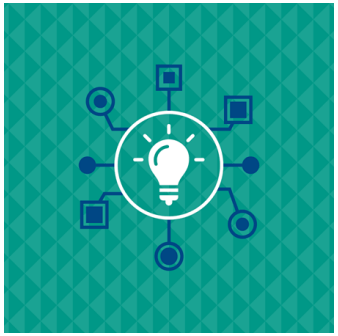
Essentials of Safe Care

- Improvement Collaborative
- Safety Climate Measurement
- Learning System

Learning System

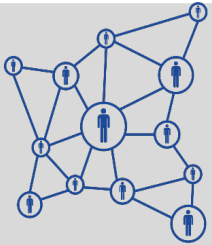
The **SPSP Learning System** will be a key element of our work and underpins all our activities. It aims to accelerate sharing of learning and improvement work through a range of engagement and learning opportunities.

Hosting webinars



Sharing data, supporting measurement and Evaluation

Supporting Networks



Producing evidence summaries and case studies studies

SPSP Mental Health: Update

Jonathan O'Reilly
Senior Improvement Advisor
Healthcare Improvement Scotland

Improvement Collaborative

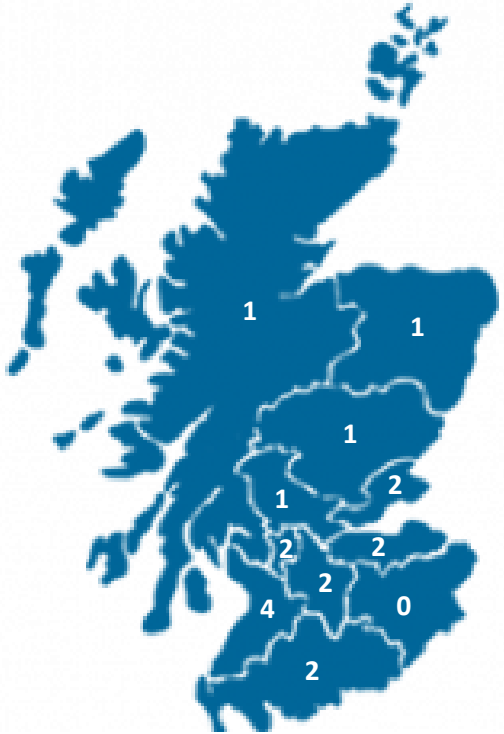
Improvement Collaborative April ‘22 – March ‘23

‘From Observation to Intervention’ guidance into practice

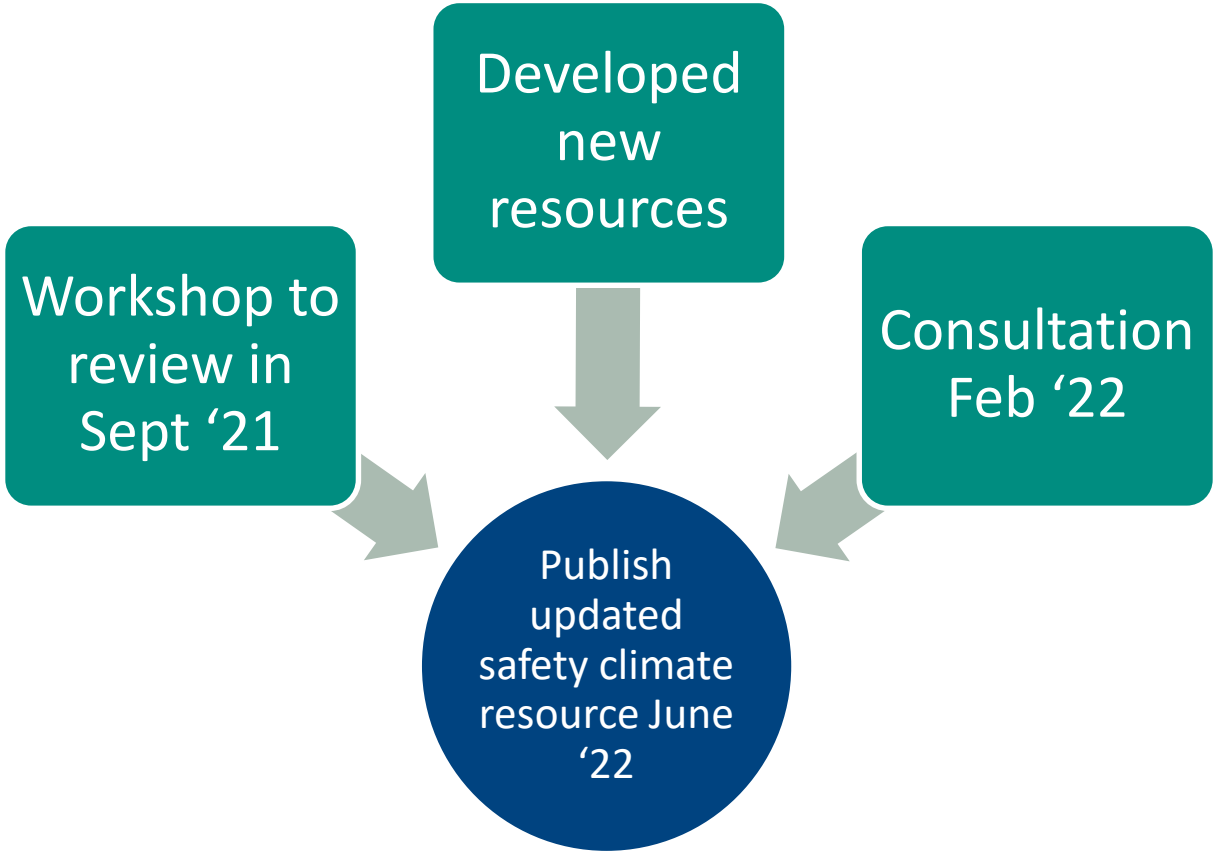
Reduce and improve the use of **restraint** practices

Reduce and improve the use of **seclusion** practices

Creating the Conditions for Change



Safety Climate Resource



Learning System

Webinar Series 2022

Improving Observation Practice – Policy to Practice

21 March 2022, 1pm

Safety climate – What is safety climate and why is it important

16 June 2022, 1pm

Webinar 3 – Tbd

September 2022

Case Studies 2022

NHS Lothian: Improving Observation Practice – Policy to Practice

The State Hospital: Using the Essential of Safe Care to understand your system

The State Hospital: Implementing Clinical and Support Services Operating Procedure

Poll

What would you like the topic of our 3rd learning system webinar to be?

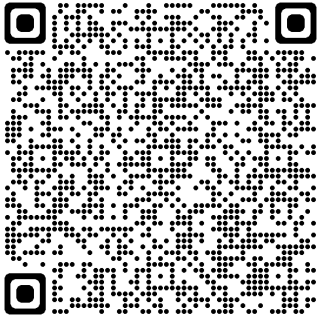
a) Essentials of Safe Care: Creating the conditions for safe care
b) Learning from covid: an inpatient perspective
c) Substance use in inpatient mental health

Or share your ideas in the chat.
Begin your idea with **W3:**

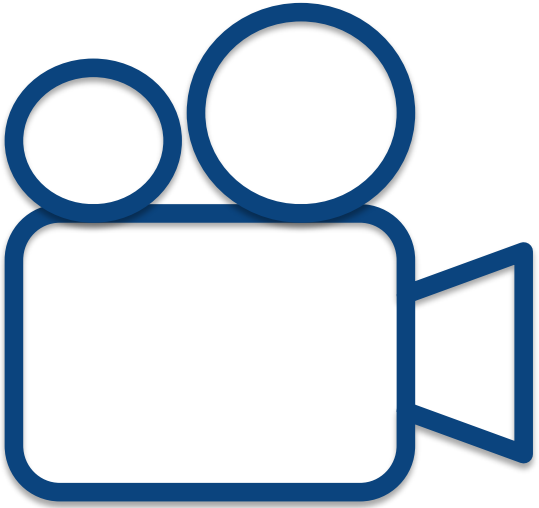
SPSP MH Resources

Improvement resources: https://tinyurl.com/yc5mc9xe

Learning system: https://bit.ly/3B4PlLJ



The following section of the webinar will be recorded.



If you don't want to be included in the recording, please ensure your camera is off

Improving Observation Practice in NHS Lothian

From Policy to Practice

Jenny Revel
Clinical Academic Mental Health Nurse,
Royal Edinburgh Hospital

Background

- ‘Observation’ is the practice of increasing the ratio and proximity of staff in response to heightened risk in inpatient settings
- Most often for self-harm, violence and aggression, disinhibition
- Practice of observation bound up in culture
- Can be stigmatising, punitive, dehumanising
- Relationship with patient safety not clear

Drivers for Change

- Change attempted in 2002 with CRAG
- Mental Welfare Commission for Scotland reports 2012/13
- Scottish Government attention
- Local SAEs
- Publication of Healthcare Improvement Scotland guidance in 2019

Creating conditions for change

- Setting up steering group
- Senior leadership support
- Becoming multi-disciplinary
- Awareness sessions (ethos, changing language)
- Involvement by patient representative groups

Q. How do you take a national guidance document and translate it into a policy that works on the ground?

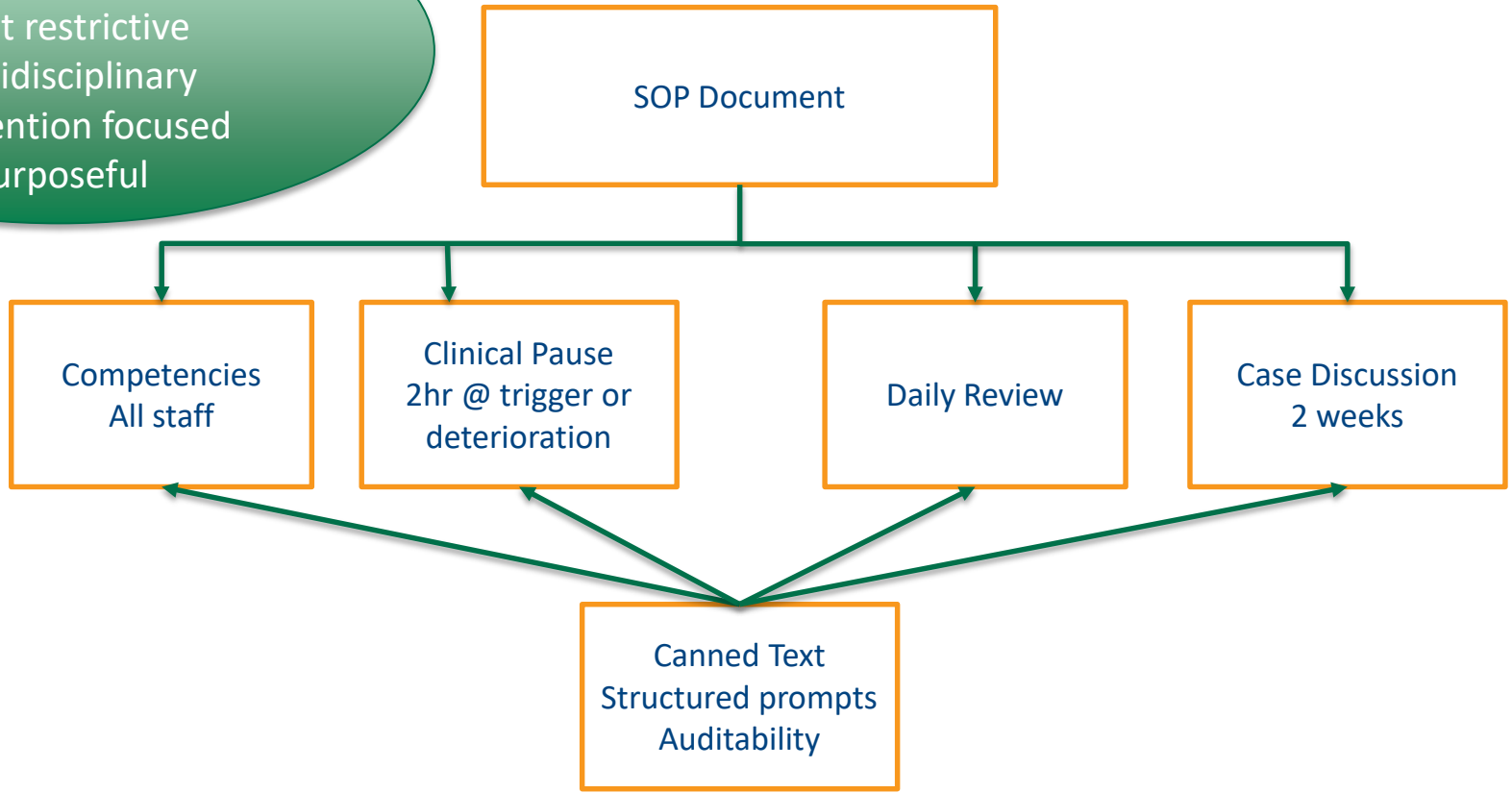
- Understand the system
- Reflected on problems
- Tap into context in which decisions around observation are made (high risks, blame, accountability)
- Ask staff, and ask again

Develop aims and change theory

- Encourage person-centredness, creativity, flexibility
- Prevent missed opportunities, surveillance, entrapment, loss of skills
- develop a policy that permits flexible models and provide organisational permission for thinking differently
- develop processes that support decision-making in the context of high levels of risk

REAS CI Standard Operating Procedure

Ethos:
Flexibility
Least restrictive
Multidisciplinary
Intervention focused
Purposeful

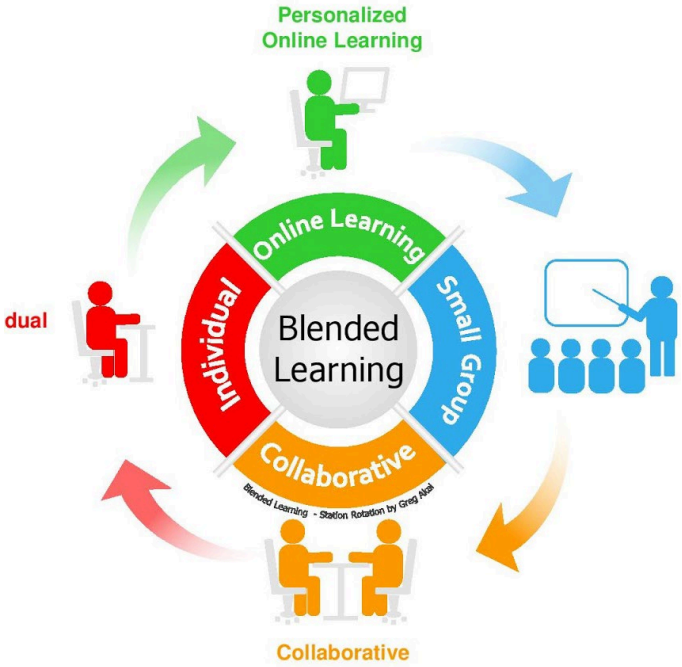


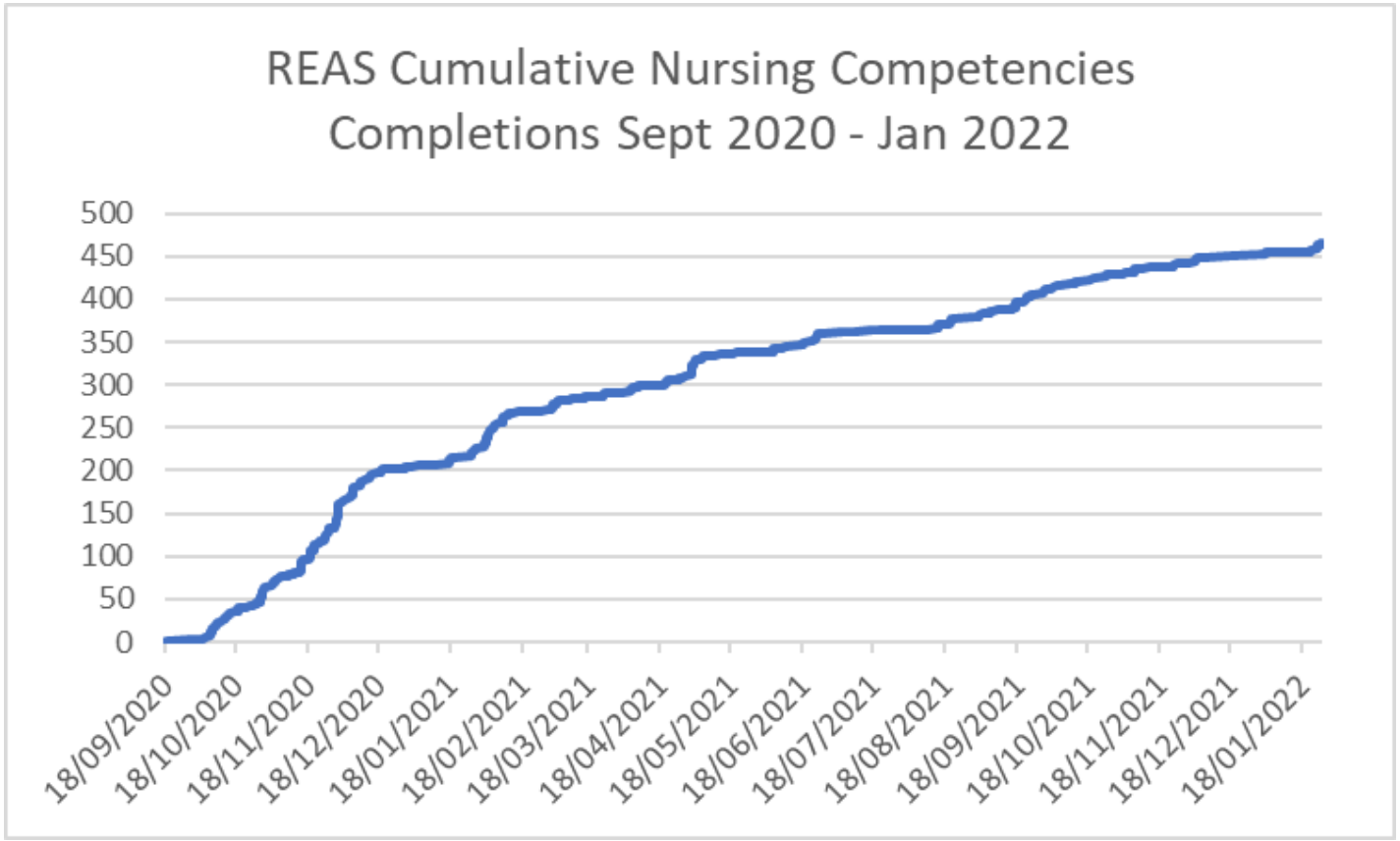
Testing and Implementing

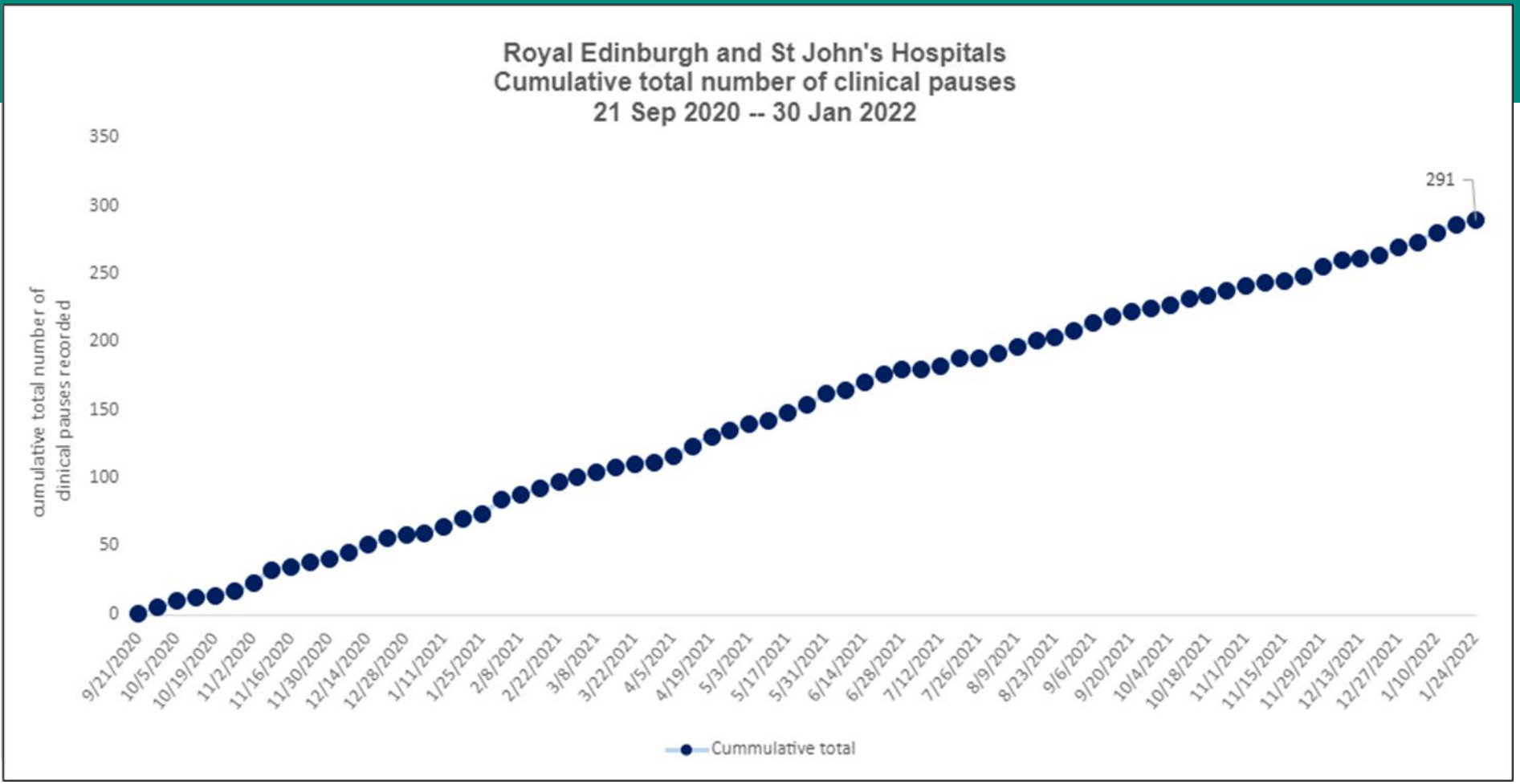
- Challenge: small test of change or whole service implementation
- Early discussions about evaluation with stakeholders
- Build in method of evaluation/audit – create sustainability
- Focus efforts on defined processes e.g. Clinical Pause, Case Discussion, Competencies
- Use data to customise training and improve implementation

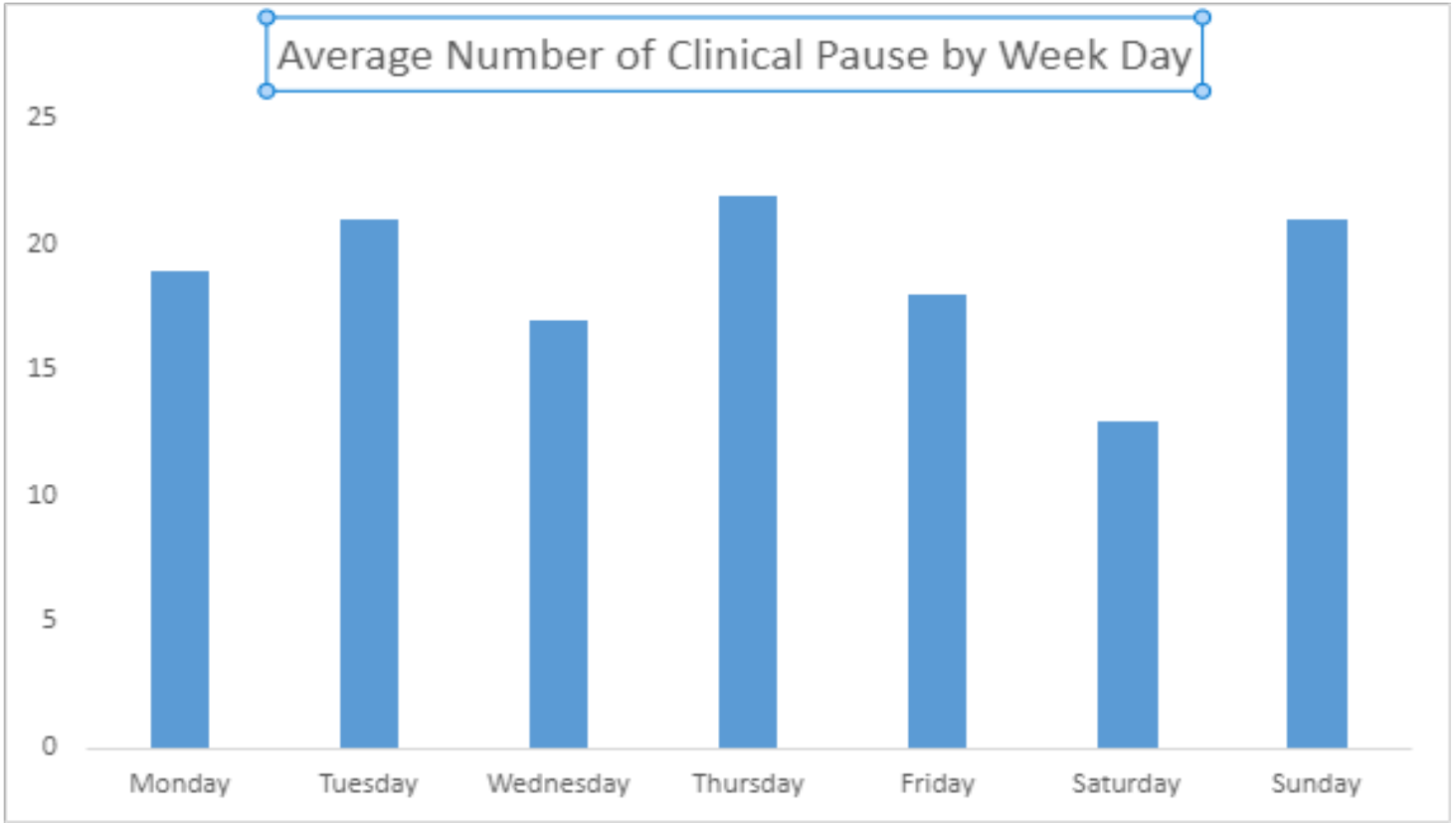
Spread

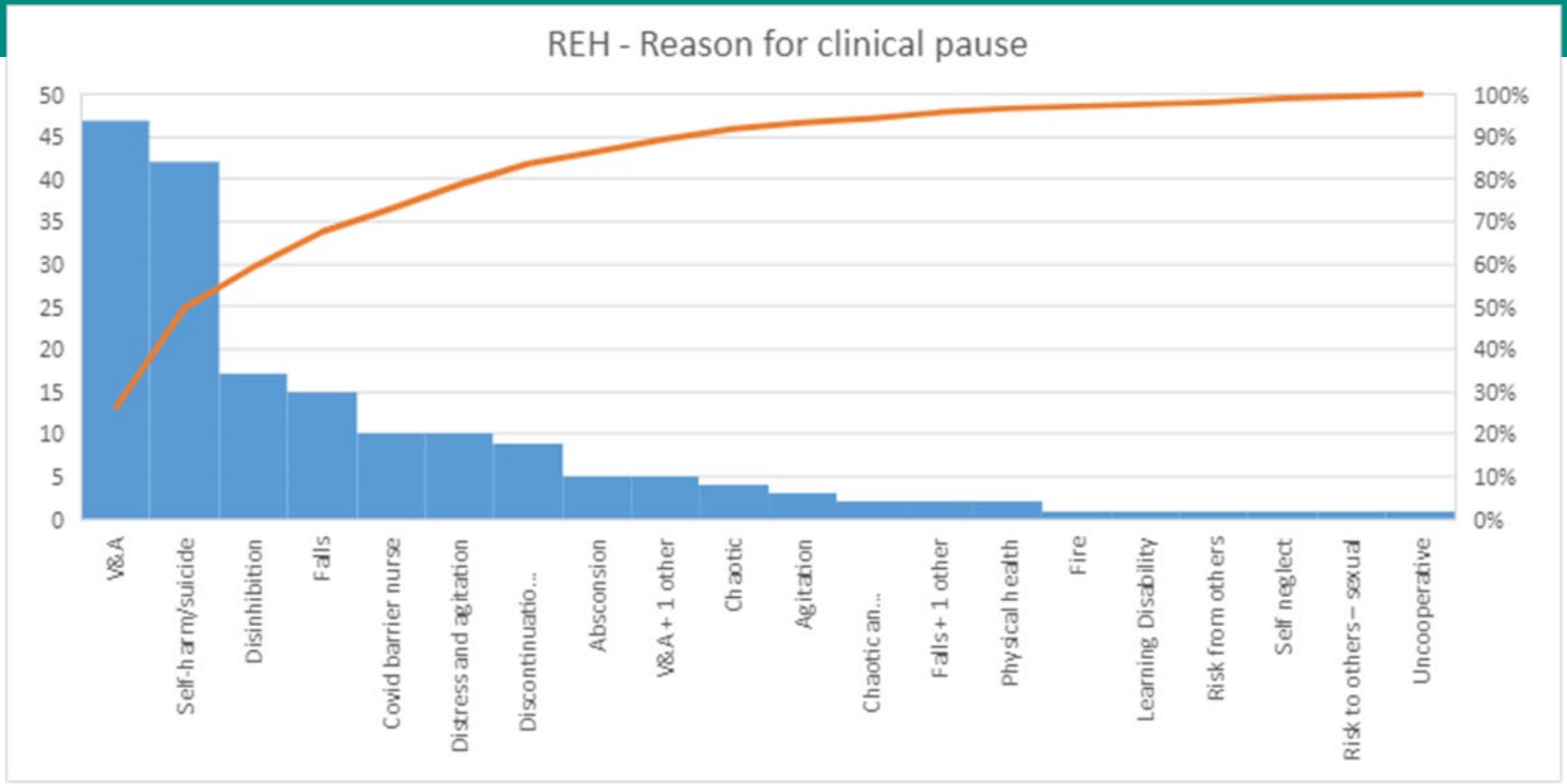
- Sharing learning nationally through HIS
- Sharing learning with MH areas outside REAS
- Spreading to non-mental health areas e.g. acute general hospitals
- Developing training modules




REAS Cumulative Nursing Competencies Completions Sept 2020 - Jan 2022
500
450
400
350
300
250
200
150
100
50
0
18/09/2020
18/10/2020
18/11/2020
18/12/2020
18/01/2021
18/02/2021
18/03/2021
18/04/2021
18/05/2021
18/06/2021
18/07/2021
18/08/2021
18/09/2021
18/10/2021
18/11/2021
18/12/2021
18/01/2022


Royal Edinburgh and St John's Hospitals
Cumulative total number of clinical pauses
21 Sep 2020 -- 30 Jan 2022
cumulative total number of clinical pauses recorded
350
300
250
200
150
100
50
0
291
9/21/2020
10/5/2020
10/19/2020
11/2/2020
11/16/2020
11/30/2020
12/14/2020
12/28/2020
1/11/2021
1/25/2021
2/8/2021
2/22/2021
3/8/2021
3/22/2021
4/5/2021
4/19/2021
5/3/2021
5/17/2021
5/31/2021
6/14/2021
6/28/2021
7/12/2021
7/26/2021
8/9/2021
8/23/2021
9/6/2021
9/20/2021
10/4/2021
10/18/2021
11/1/2021
11/15/2021
11/29/2021
12/13/2021
12/27/2021
1/10/2022
1/24/2022
Cummulative total


Average Number of Clinical Pause by Week Day
25
20
15
10
5
0
Monday
Tuesday
Wednesday
Thursday
Friday
Saturday
Sunday


REH - Reason for clinical pause
50
45
40
35
30
25
20
15
10
5
0
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
V&A
Self-harm/suicide
Disinhibition
Falls
Covid barrier nurse
Distress and agitation
Discontinuatio...
Absconsion
V&A + 1 other
Chaotic
Agitation
Chaotic an...
Falls + 1 other
Physical health
Fire
Learning Disability
Risk from others
Self neglect
Risk to others – sexual
Uncooperative

Continuous Intervention Days per Service Area				
Service	**Total (days)**	**Range (days)**	**Number of CI's**	**Average days**
Acute Adult	430	0-76	49	8.8
OPMH	140	1-60	16	8.8
Rehabilitation	134	5-55	6	22.3
Total	**704**	**NA**	**71**	**9.9**

REAS Mar – Aug 2021

Reason for Continuous intervention >14 days by Service Area						
Service	**Disinhibition**	**Distress and agitation**	**Self-harm / suicidal ideation**	**Violence and aggression**	**Unpredictable**	**Total**
Acute Adult	2	1	4	1	1	**9**
OPMH	0	0	0	2	0	**2**
Rehabilitation	0	1	0	2	0	**3**
Total (reason for CI)	**2**	**2**	**4**	**5**	**1**	**14**

REAS Mar – Aug 2021

Sustainability…

- Use data to understand system e.g. who, what, where, when, why
- Identify gaps
- Compare data with other data sources e.g. Datix, HEMPA
- Share improvement ideas
- Identify spin-off improvement projects
- Create conditions for change…

Simon Porter

Royal Edinburgh Hospital

Patient's Council

Questions?

Next steps

- Resources from today - available soon on our Learning System webpage
- Learning System Webinar 2: Safety Climate – 16th June 2022

Feedback

Please take the time now to complete our evaluation polls.

Keep in touch

His.mhportfolio@nhs.scot

@SPSP_MH

To find out more visit ihub.scot

THANK
YOU!